

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0020495</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Brother James Court</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/02</u> to <u>6/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>2508 St. James Road</u> <u>Springfield</u> <u>62707</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Sangamon</u>																											
<b>Telephone Number:</b> <u>(217) 544-4876</u> <b>Fax #</b> <u>(217) 544-4877</u>																											
<b>IDPA ID Number:</b> <u>43/1588535004</u>																											
<b>Date of Initial License for Current Owners:</b> <u>October 1, 1975</u>																											
<b>Type of Ownership:</b>																											
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>																											
<input checked="" type="checkbox"/> Charitable Corp.																											
<input type="checkbox"/> Trust																											
<b>IRS Exemption Code</b> <u>501(c)(3)</u>																											
<input type="checkbox"/> <b>PROPRIETARY</b>																											
<input type="checkbox"/> Individual																											
<input type="checkbox"/> Partnership																											
<input type="checkbox"/> Corporation																											
<input type="checkbox"/> "Sub-S" Corp.																											
<input type="checkbox"/> Limited Liability Co.																											
<input type="checkbox"/> Trust																											
<input type="checkbox"/> Other																											
<input type="checkbox"/> <b>GOVERNMENTAL</b>																											
<input type="checkbox"/> State																											
<input type="checkbox"/> County																											
<input type="checkbox"/> Other																											
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Daniel J. Call</u> <b>Telephone Number:</b> <u>(217) 793-3363</u>		<table border="1"> <tr> <td rowspan="2"> <b>Officer or Administrator of Provider</b> </td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) <u>Brother David Sarnecki</u></td> </tr> <tr> <td rowspan="4"> <b>Paid Preparer</b> </td> <td colspan="2">(Title) <u>Administrator</u></td> </tr> <tr> <td colspan="2">(Signed) _____</td> </tr> <tr> <td colspan="2">(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) <u>Daniel J. Call, CPA, Partner</u></td> </tr> <tr> <td colspan="2">           (Firm Name &amp; Address) <u>Sikich Gardner &amp; Co, LLP</u>  <u>1000 Churchill Road, Springfield, IL 62702</u> </td> <td></td> </tr> <tr> <td colspan="2">           (Telephone) <u>(217) 793-3363</u> <b>Fax #</b> <u>(217) 793-3016</u> </td> <td></td> </tr> <tr> <td colspan="3"> <b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> </td> <td> <b>Phone #</b> (217) 782-1630       </td> </tr> </table>		<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>Brother David Sarnecki</u>		<b>Paid Preparer</b>	(Title) <u>Administrator</u>		(Signed) _____		(Date) _____		(Print Name and Title) <u>Daniel J. Call, CPA, Partner</u>		(Firm Name & Address) <u>Sikich Gardner &amp; Co, LLP</u> <u>1000 Churchill Road, Springfield, IL 62702</u>			(Telephone) <u>(217) 793-3363</u> <b>Fax #</b> <u>(217) 793-3016</u>			<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>			<b>Phone #</b> (217) 782-1630
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	(Type or Print Name) <u>Brother David Sarnecki</u>																										
<b>Paid Preparer</b>	(Title) <u>Administrator</u>																										
	(Signed) _____																										
	(Date) _____																										
	(Print Name and Title) <u>Daniel J. Call, CPA, Partner</u>																										
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## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Brother James Court# 0020495 Report Period Beginning: 07/01/02 Ending: 6/30/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>93</u>	Intermediate/DD	<u>93</u>	<u>33,945</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>33,945</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>32,627</u>	<u>1,095</u>		<u>33,722</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,627</u>	<u>1,095</u>		<u>33,722</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 99.34%

D. How many bed-hold days during this year were paid by Public Aid?

1,734 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/01/1975

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30 Fiscal Year: 6/30

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number **Brother James Court**# **0020495**

Report Period Beginning:

**07/01/02**

Ending:

**6/30/03****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	275,286	21,547	1,173	298,006		298,006		298,006		1
2	Food Purchase		145,081		145,081		145,081		145,081		2
3	Housekeeping	56,838	15,448	3,691	75,977		75,977		75,977		3
4	Laundry	55,614	3,349		58,963		58,963		58,963		4
5	Heat and Other Utilities			117,354	117,354		117,354		117,354		5
6	Maintenance	88,954		77,365	166,319		166,319		166,319		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	476,692	185,425	199,583	861,700		861,700		861,700		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,220,426	40,882	4,202	1,265,510		1,265,510		1,265,510		10
10a	Therapy			344	344		344		344		10a
11	Activities	6,292			6,292		6,292		6,292		11
12	Social Services	157,013		20,857	177,870		177,870		177,870		12
13	Nurse Aide Training			2,228	2,228		2,228		2,228		13
14	Program Transportation			11,070	11,070		11,070		11,070		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,383,731	40,882	41,101	1,465,714		1,465,714		1,465,714		16
	<b>C. General Administration</b>										
17	Administrative	61,017		432	61,449		61,449		61,449		17
18	Directors Fees										18
19	Professional Services			39,747	39,747		39,747		39,747		19
20	Dues, Fees, Subscriptions & Promotions			3,386	3,386		3,386		3,386		20
21	Clerical & General Office Expenses	125,813	40,785	54,575	221,173		221,173	(18,239)	202,934		21
22	Employee Benefits & Payroll Taxes			454,913	454,913		454,913		454,913		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			45,681	45,681		45,681		45,681		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	186,830	40,785	598,734	826,349		826,349	(18,239)	808,110		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,047,253	267,092	839,418	3,153,763		3,153,763	(18,239)	3,135,524		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **Brother James Court**

#0020495

Report Period Beginning: 07/01/02 Ending: 6/30/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			190,429	190,429		190,429	141,361	331,790			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			460,429	460,429		460,429	(128,639)	331,790			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			211,233	211,233		211,233		211,233			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			211,233	211,233		211,233		211,233			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,047,253	267,092	1,511,080	3,825,425		3,825,425	(146,878)	3,678,547			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

6/30/03

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

OHF USE ONLY									
48		49		50		51		52	

		1	2
		Amount	Reference
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(128,639)	34
35	Other- Attach Schedule		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (128,639)	36
	(sum of SUBTOTALS		
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (146,878)	37

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

	<b>1</b>	<b>2</b>	<b>3</b>
1. Depreciation on a car used for business			
2. Depreciation on a truck used for business			
3. Depreciation on a boat used for business			
4. Depreciation on a plane used for business			
5. Depreciation on a house used for business			
6. Depreciation on a car used for personal purposes			
7. Depreciation on a truck used for personal purposes			
8. Depreciation on a boat used for personal purposes			
9. Depreciation on a plane used for personal purposes			
10. Depreciation on a house used for personal purposes			

(See instructions.)		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$ NONE</b>	47

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/02

Ending: 6/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

6/30/03

[illegible]

## Summary B

6/30/03

[illegible]

Facility Name & ID Number Brother James Court# 0020495

Report Period Beginning:

07/01/02

Ending:

6/30/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A		Franciscan Brothers of the Holy Cross	Springfield	Religious Order
				Springfield Developmental Center	Springfield	Day Training Prog.
				Weber Care Corp.	Springfield	Community Living Facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Facility Rent	\$ 270,000	Franciscan Brothers of the Holy Cross	100.00%	\$	(270,000)	1
2	V	30 Depreciation		Franciscan Brothers of the Holy Cross	100.00%	\$ 141,361	141,361	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 270,000			\$ 141,361	\$ * (128,639)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/02 Ending: 6/30/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brother Raphael Kreikemeier	Food Service	Head Cook	none	none	60	100.00	Salary	\$ 53,883	1.1	1
2		Supervisor									2
3	Brother Luke Morin	Resident Services	Coordinates	none	none	60	100.00	Salary	53,883	10.1	3
4		Coordinator	Resident Services								4
5	Brother Gerald Voycheck	Social Services	Social Worker	none	none	60	100.00	Salary	55,383	12.1	5
6		Director									6
7	Brother David Sarnecki	Administrator	Administrator	none	none	60	100.00	Salary	61,017	17.1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 224,166		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Brother James Court# 0020495 Report Period Beginning: 07/01/02 Ending: 6/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **Brother James Court**# **0020495**

Report Period Beginning:

**07/01/02**

Ending:

**6/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	N/A						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related							\$	\$			\$	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Page 10  
6/30/03

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ _____</b>	<b>\$ _____</b>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 **45,477**

B. General Construction Type:
 Exterior
 **Brick/Stone**

Frame
 **Steel**

Number of Stories
 **1**

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

**NONE.**

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 **N/A**

2. Number of Years Over Which it is Being Amortized:
 **N/A**

3. Current Period Amortization:
 **N/A**

4. Dates Incurred:
 **N/A**

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<b>Facility</b>			\$ <b>Not Available</b>	1
2					2
3	<b>TOTALS</b>			\$	3

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/02

Ending:

6/30/03

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	93	1975	1975	\$ 1,003,250	\$	30	\$ 33,442	\$ 33,442	\$ 962,092
5		1996	1996	1,251,493		30	41,716	41,716	292,015
6		1997	1997	1,256,490		30	41,883	41,883	235,005
7									
8									
<b>Improvement Type**</b>									
9	New Wing - Heating and air conditioning	1997		18,883		30	629	629	3,829
10	Repave parking lot	1986		42,236		10			42,236
11	Painting/decorating	1979		2,591		5			2,591
12	BJC - building improvements	1980		16,233		11			16,233
13	BJC - building improvements	1984		21,419		10			21,419
14	BJC - remodeling	1987		69,555		10			69,555
15	BJC - water line	1987		14,120		20	706	706	10,590
16	Insulation	1991		9,175		15	612	612	7,289
17	Electrical repair	1991		613		10			613
18	Boiler room remodeling	1992		15,089		20	755	755	8,459
19	Tank removal	1992		8,500		10			8,500
20	Dishwashing room sewer	1992		10,680		20	534	534	6,141
21	BJC - Steam line	1985		14,479		10			14,479
22	BJC - building improvements	1975		19,600		24			19,600
23	BJC - Dining area remodeling	1976		34,951		10			34,951
24	BJC - sidewalk/patio	1976		3,545		10			3,545
25	BJC - Bike rink	1978		2,500		5			2,500
26	BJC - Air conditioning system	1979		22,876		10			22,876
27	BJC - site improvement	1979		1,440		26	55	55	1,353
28	Roof	1979		12,166		10			12,166
29	Roofing	1986		45,811		10			45,811
30	Remodeling	1988		46,656		10			46,656
31	Water line	1989		3,166		20	158	158	2,295
32	Sewage treatment plant	1990		6,411		20	321	321	4,220
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/02

Ending:

6/30/03

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Tank removal	1991	\$ 9,809	\$	10	\$	\$	\$ 9,809		37
38	Parking lot	1992	10,452		10	436	436	10,452		38
39	Paint restrooms	1992	230		5			230		39
40	Boiler room remodeling	1993	15,106		20	755	755	7,559		40
41	Repave parking lot	1994	850		10	85	85	744		41
42	Pump	1994	734		10	73	73	672		42
43	Air conditioner work	1994	943		10	94	94	857		43
44	Boiler room project	1994	170,330		20	8,517	8,517	75,439		44
45	Land improvement - trees	1996	3,470		20	174	174	1,186		45
46	BJC - improvements	1998	15,712		30	524	524	2,793		46
47	Water line repair	1999	3,101		10	310	310	1,163		47
48	Land improvement - trees	1999	25,849		20	1,293	1,293	4,954		48
49	Gate	1999	550		5	110	110	403		49
50	Remodeling	1999	5,773		10	577	577	2,069		50
51	Floor	2000	1,683		7	240	240	761		51
52	Total Life Center	1998	122,261		30	4,075	4,075	20,716		52
53	Leaschold improvements	1985	15,200		10			15,200		53
54	Leaschold improvements	1986	19,507		10			19,507		54
55	Painting	1987	9,922		3			9,922		55
56	Steel door	1987	6,020		10			6,020		56
57	Window replacement	1987	2,013		10			2,013		57
58	Generator switch	1988	3,335		10			3,335		58
59	Remodel lobby	1989	156,996	5,233	30	5,233		71,084		59
60	Bus hut	1989	4,715	314	15	314		4,296		60
61	Water heater	1989	6,721		10			6,721		61
62	Transfer switch	1989	1,127		10			1,127		62
63	Heat-energy panel	1989	8,633		10			8,633		63
64	Leaschold improvements	1989	6,629	77	10	77		6,513		64
65	Roof repair	1990	6,928		10			6,928		65
66	Remodeling	1990	6,953	232	30	232		3,052		66
67	Overhead door	1990	1,220		10			1,220		67
68	Kitchen tanks	1990	3,089		10			3,089		68
69	Plastering	1990	2,586		10			2,586		69
70	TOTAL (lines 4 thru 69)		\$ 4,602,375	\$ 5,856		\$ 143,930	\$ 138,074	\$ 2,208,072		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 4,602,375	\$ 5,856		\$ 143,930	\$ 138,074	\$ 2,208,072		1
2	Remodel ceiling	1990	2,970		10			2,970		2
3	Leasehold improvements	1990	26,015		10			26,015		3
4	Leasehold improvements	1991	2,141		10			2,141		4
5	Window replacement	1992	2,750		10			2,750		5
6	Cafeteria doors	1993	11,918	993	10	993		11,918		6
7	Plumbing work	1994	6,858	686	10	686		6,172		7
8	Painting	1995	3,076	308	10	308		2,460		8
9	Wall and door repair	1995	2,596	259	10	259		2,077		9
10	Door	1996	656	66	10	66		459		10
11	Roof repair	1996	5,985	598	10	598		4,189		11
12	Painting	1996	1,620		10			1,620		12
13	Furnace	1996	502	50	10	50		351		13
14	Land improvements	1996	1,385		3			1,385		14
15	Repairs	1996	10,702	103	5	103		10,394		15
16	Grip caps	1996	1,575		5			1,575		16
17	Boiler	1996	3,335	334	10	334		2,335		17
18	Bedding	1996	1,505		3			1,505		18
19	Air deflectors	1996	381		3			381		19
20	Shower	1996	259		5			259		20
21	Sewer	1996	9,387	939	10	939		6,571		21
22	Painting	1996	4,928	493	10	493		3,450		22
23	Roof repair	1997	798	80	10	80		479		23
24	Drapes	1997	4,500		5			4,500		24
25	Floor coverings	1997	1,722	172	10	172		1,033		25
26	Drapes - Life Center	1997	3,153		5			3,153		26
27	Floor coverings - Life Center	1997	4,422	442	10	442		2,653		27
28	Painting - Life Center	1997	8,917	892	10	892		5,350		28
29	Floor	1997	2,658	320	10	320		2,029		29
30	Alarms/Smoke detectors	1998	20,108	4,022	5	4,022		17,794		30
31	Snack lounge - remodeling	1999	2,847	569	5	569		2,467		31
32	Roof repairs	1999	846	85	10	85		360		32
33	Carpet in front office	1999	8,881	1,776	5	1,776		7,401		33
34	TOTAL (lines 1 thru 33)		\$ 4,761,771	\$ 19,043		\$ 157,117	\$ 138,074	\$ 2,346,268		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,761,771	\$ 19,043		\$ 157,117	\$ 138,074	\$ 2,346,268	1
2	Yard signs	1999	2,825	282	10	282		1,154	2
3	New tees & valves	1999	11,685	1,168	10	1,168		4,771	3
4	Vinyl wall covering	1999	1,127	113	10	113		451	4
5	Shower room repairs	1999	8,220	822	10	822		3,288	5
6	Connection fees for sewer project	1998	7,438	744	10	744		3,409	6
7	Tree removal	1999	9,857	986	10	986		3,779	7
8	Condenser	1999	12,396	1,240	10	1,240		4,752	8
9	Leasehold improvements	1999	2,598	518	5	518		1,992	9
10	Landscaping	1999	18,255	1,826	10	1,826		6,769	10
11	Drop rod assembly	1999	6,408	641	10	641		2,403	11
12	Fencing	1999	3,840	384	10	384		1,408	12
13	Trees	1999	9,905	990	10	990		3,549	13
14	Roof repairs	2000	2,300	230	10	230		767	14
15	Tile floor - resident wing	2000	34,740	3,474	10	3,474		11,580	15
16	Painting	2000	6,352	1,270	5	1,270		4,129	16
17	Window replacement	2000	2,009	201	10	201		653	17
18	Leasehold improvements	1999	5,754	1,151	5	1,151		3,876	18
19	Cabinet modification	1999	4,520	646	7	646		2,260	19
20	Professional electrical services	1999	17,310	1,161	15	1,161		4,643	20
21	New sign out front	1999	900	180	5	180		720	21
22	Masonry work for BJC	1999	23,465	1,564	15	1,564		6,257	22
23	Professional plumbing & heating services	1999	31,000	2,067	15	2,067		8,267	23
24	Remodeling	1999	19,524	1,302	15	1,302		5,207	24
25	Parking lot stripes	2000	1,549	310	5	310		904	25
26	Painting basement ceiling	2000	664	133	5	133		332	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,006,512	\$ 42,446		\$ 180,520	\$ 138,074	\$ 2,433,588	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,006,512	\$ 42,446		\$ 180,520	\$ 138,074	\$ 2,433,588	1
2	Draperies	2001	10,881	2,176	5	2,176		4,035	2
3	Ramp area decorating	2001	14,387	2,877	5	2,877		5,515	3
4	Painting & wallcovering	2001	8,058	1,612	5	1,612		2,955	4
5	Air curtain	2001	1,812	259	7	259		475	5
6	Recepticles - Bedrooms	2001	9,820	1,964	5	1,964		3,273	6
7	Shower room floor repair	2002	1,123	112	10	112		168	7
8	Door repairs	2002	6,197	620	10	620		838	8
9	Boiler repair	2002	3,960	792	5	792		1,188	9
10	Draperies	2002	4,200	840	5	840		1,190	10
11	Architect fees - remodel bathroom area	2002	9,863	3,288	3	3,288		4,384	11
12	Repave sidewalks	2002	810	81	10	81		101	12
13	Tuckpointing	2002	1,490	149	10	149		174	13
14	Repair floors	2002	2,688	269	10	269		313	14
15	Parking lot blacktop	2000	49,310		15	3,287	3,287	9,040	15
16	Keylock pad	2002	580	53	10	53		53	16
17	Strip and refinish floors	2002	8,702	601	10	601		601	17
18	Hot water storage tank	2002	4,408	220	10	220		220	18
19	Doors & frames	2003	3,733	93	10	93		93	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,148,534	\$ 58,452		\$ 199,813	\$ 141,361	\$ 2,468,204	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/02

Ending:

6/30/03

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 783,440	\$ 105,160	\$ 105,160	\$		\$ 496,949	71
72	Current Year Purchases	43,885	3,491	3,491			3,491	72
73	Fully Depreciated Assets	781,391	5,941	5,941			781,391	73
74								74
75	TOTALS	\$ 1,608,716	\$ 114,592	\$ 114,592	\$		\$ 1,281,831	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Resident	Trucks	Various	\$ 72,449	\$ 11,482	\$ 11,482	\$		\$ 52,238	76
77	Transportation	Vans (& wheelchair lift)	Various	34,424	2,709	2,709			28,102	77
78		Cars	Various	41,823	3,194	3,194			40,032	78
79										79
80	TOTALS			\$ 148,696	\$ 17,385	\$ 17,385	\$		\$ 120,372	80

## E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,905,946	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 190,429	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 331,790	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 141,361	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,870,407	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92	Bathroom addition	\$ 142,693	92
93			93
94			94
95		\$ 142,693	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

**A. Building and Fixed Equipment (See instructions.)**

**1. Name of Party Holding Lease:** **Franciscan Brothers of the Holy Cross (related party)**

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

**If NO, see instructions.**

☐ YES      ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*\*

**8. List separately any amortization of lease expense included on page 4, line 34.**

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: \*

**B. Equipment-Excluding Transportation and Fixed Equipment.** (See instructions.)

**15. Is Movable equipment rental included in building rental?**

☐ YES      ☒ NO

16. Rental Amount for movable equipment: \$ NONE Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

**10. Effective dates of current rental agreement:**

### Beginning 1975

Ending **2011**

**11. Rent to be paid in future years under the current rental agreement:**

**Fiscal Year Ending**

### Annual Rent

12.                    6/30/2004       \$ 270,000

12.	<u>6/30/2004</u>	\$ <u>270,000</u>
13.	<u>6/30/2005</u>	\$ <u>270,000</u>

14.	<u>6/30/2006</u>	\$ <u>270,000</u>
-----	------------------	-------------------

**\* If there is an option to buy the building, please provide complete details on attached schedule.**

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE <u>40</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE <u>85</u>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$		\$			
2	Books and Supplies		248		248		
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)		1,980		1,980		
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	2,228	\$	2,228		
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,228				

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,654,411	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	522,663		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,845		6
7	Other Prepaid Expenses	5,953		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,203,872	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,221,820		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	758,444		15
16	Equipment, at Historical Cost	1,757,412		16
17	Accumulated Depreciation (book methods)	(1,824,540)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in progress</u>	142,693		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,055,829	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,259,701	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 119,264	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,497		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued vacation</u>	65,818		36
37	<u>Other (miscellaneous)</u>	2,307		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 228,886	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 228,886	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,030,815	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,259,701	\$	48

\*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,032,503	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,032,503	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(1,688)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,688)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,030,815	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,475,049	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,475,049	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	18,634	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,249	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 25,883	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	168,676	24
25	Interest and Other Investment Income***	78,658	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 247,334	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Fundraising</b>	72,937	28
28a	<b>D.D. Day Training</b>	2,534	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 75,471	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,823,737	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	861,700	31
32	Health Care	1,465,714	32
33	General Administration	826,349	33
	<b>B. Capital Expense</b>		
34	Ownership	460,429	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	211,233	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,825,425	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,688)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,688)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning: 07/01/02

Ending: 6/30/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,948	2,000	\$ 45,094	\$ 22.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,423	2,904	46,540	16.03	3
4	Licensed Practical Nurses	11,678	12,496	197,221	15.78	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	3,120	3,120	55,383	17.75	11
12	Dietician					12
13	Food Service Supervisor	3,120	3,120	53,883	17.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,878	26,673	221,403	8.30	15
16	Dishwashers					16
17	Maintenance Workers	5,688	5,988	88,954	14.86	17
18	Housekeepers	6,101	6,176	56,838	9.20	18
19	Laundry	4,160	6,424	55,614	8.66	19
20	Administrator	3,120	3,120	61,017	19.56	20
21	Assistant Administrator					21
22	Other Administrative			6,292		22
23	Office Manager					23
24	Clerical	7,501	8,545	125,813	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,320	8,960	101,630	11.34	28
29	Resident Services Coordinator	3,120	3,120	53,883	17.27	29
30	Habilitation Aides (DD Homes)	79,858	82,494	877,688	10.64	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,035	175,140	\$ 2,047,253 *	\$ 11.69	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	30	\$ 1,173	1.3	35
36	Medical Director	Various	2,400	9.3	36
37	Medical Records Consultant	6	228	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Various	1,000	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Various	2,425	12.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	59	2,360	12.3	43
44	Activity Consultant				44
45	Social Service Consultant	Various	11,100	12.3	45
46	Other(specify)				46
47	Psychologist Consultant	Various	7,200	12.3	47
48					48
49	TOTAL (lines 35 - 48)	95	\$ 27,886		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number    **Brother James Court**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

#   0020495

Page 21

Report Period Beginning:    07/01/02    Ending:    6/30/03

<p><b>A. Administrative Salaries</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Brother David Sarnecki</td> <td>Administrator</td> <td></td> <td style="text-align: right;">\$ 61,017</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 61,017</td> </tr> </tbody> </table> <p><b>B. Administrative - Other</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Description</th> <th style="width: 30%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Background checks</td> <td style="text-align: right;">\$ 432</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td style="text-align: right;">\$ 432</td> </tr> </tbody> </table> <p><b>C. 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Schedule of Non-Cash Compensation Paid to Owners or Employees</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Description</th> <th style="width: 10%;">Line #</th> <th style="width: 50%;">Amount</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td>TOTAL</td> <td> </td> <td style="text-align: right;">\$</td> </tr> </tbody> </table>	Description	Amount	Workers' Compensation Insurance	\$ 40,099	Unemployment Compensation Insurance	15,888	FICA Taxes	128,783	Employee Health Insurance	170,818	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Pension Contribution	84,996	Life Insurance	6,422	Other Employee Benefits	7,907									TOTAL (agree to Schedule V, line 22, col.8)	\$ 454,913	Description	Line #	Amount																															TOTAL		\$	<p><b>F. 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Stratton & Giganti	Legal	11,060																																																																																																																																																																																																											
Other	Administrative	841																																																																																																																																																																																																											
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 39,747																																																																																																																																																																																																											
Description	Amount																																																																																																																																																																																																												
Workers' Compensation Insurance	\$ 40,099																																																																																																																																																																																																												
Unemployment Compensation Insurance	15,888																																																																																																																																																																																																												
FICA Taxes	128,783																																																																																																																																																																																																												
Employee Health Insurance	170,818																																																																																																																																																																																																												
Employee Meals																																																																																																																																																																																																													
Illinois Municipal Retirement Fund (IMRF)*																																																																																																																																																																																																													
Pension Contribution	84,996																																																																																																																																																																																																												
Life Insurance	6,422																																																																																																																																																																																																												
Other Employee Benefits	7,907																																																																																																																																																																																																												
TOTAL (agree to Schedule V, line 22, col.8)	\$ 454,913																																																																																																																																																																																																												
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IDPH License Fee	\$																																																																																																																																																																																																												
Advertising: Employee Recruitment	2,507																																																																																																																																																																																																												
Health Care Worker Background Check (Indicate # of checks performed _____)																																																																																																																																																																																																													
Membership dues	190																																																																																																																																																																																																												
Subscriptions	689																																																																																																																																																																																																												
Less: Public Relations Expense	( )																																																																																																																																																																																																												
Non-allowable advertising	( )																																																																																																																																																																																																												
Yellow page advertising	( )																																																																																																																																																																																																												
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,386																																																																																																																																																																																																												
Description	Amount																																																																																																																																																																																																												
Out-of-State Travel	\$																																																																																																																																																																																																												
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Entertainment Expense	( )																																																																																																																																																																																																												
(agree to Sch. V, line 24, col. 8)																																																																																																																																																																																																													
TOTAL	\$																																																																																																																																																																																																												

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

<p><b>Facility Name &amp; ID Number</b>    <b>Brother James Court</b></p> <p><b>XX. GENERAL INFORMATION:</b></p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union?    <u>NO</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report?    <u>NO</u> If YES, give association name and amount.    <u>N/A</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization?    <u>NO</u>    If YES, have these costs been properly adjusted out of the cost report?    <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?    <u>NO</u>    If YES, what is the capacity?    <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases?    <u>YES</u> What was the average life used for new equipment added during this period?    <u>5-7 YEARS</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ <u>2,506</u>    Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?    <u>YES</u>    If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement?    <u>NO</u> If YES, give effective date of lease.    <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement?    YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?    YES    NO <u>X</u>    If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.    \$ <u>211,233</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?    <u>NO</u>    If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;"><b>STATE OF ILLINOIS</b></p> <p>#    <b>0020495</b>    Report Period Beginning:    <b>07/01/02</b>    Ending:    <b>6/30/03</b>    <span style="float: right;">Page 23</span></p> <hr/> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?    <u>YES</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>NO</u>    For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V.    \$ <u>NONE</u>    Has any meal income been offset against related costs?    <u>NO</u>    Indicate the amount.    \$ <u>N/A</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel?    <u>NO</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents?    <u>YES</u>    If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ <u>7,249</u> c. What percent of all travel expense relates to transportation of nurses and patients?    <u>100%</u> d. Have vehicle usage logs been maintained?    <u>YES</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use?    <u>YES</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?    <u>N/A</u> <b>g. Does the facility transport residents to and from day training?    <u>NO</u></b> <b>Indicate the amount of income earned from providing such transportation during this reporting period.    \$ <u>NONE</u></b></p> <p>(17) Has an audit been performed by an independent certified public accounting firm?    <u>YES</u> Firm Name:    <u>Sikich Gardner &amp; Co, LLP</u>    The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?    <u>YES</u>    If no, please explain.    <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?    <u>YES</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?    <u>YES</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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